VOL. 15, NO. 3 SEPT.-OCT., 1965

Inventory

A BI-MONTHLY JOURNAL ON ALCOHOL AND ALCOHOLISM

PUBLISHED BY THE N. C. ALCOHOLIC REHABILITATION PROGRAM

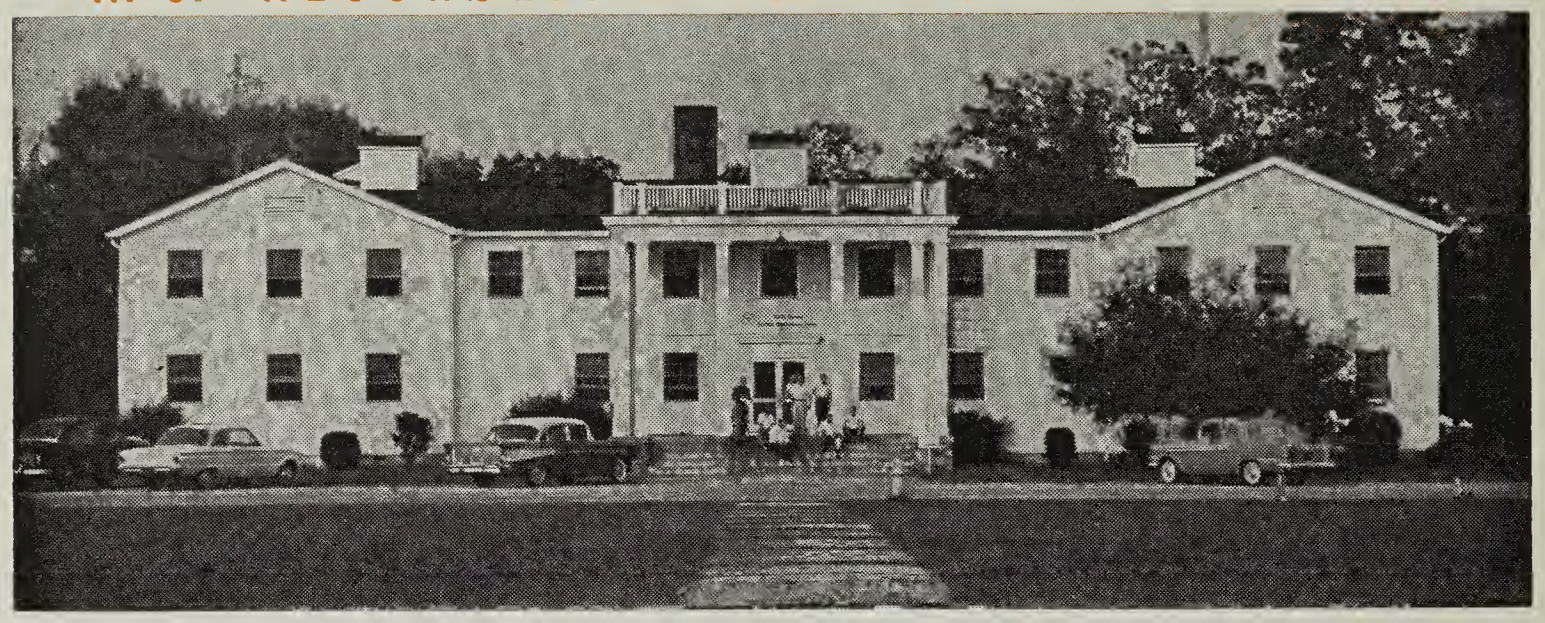
TREATMENT

REHABILITATION

EDUCATION

PREVENTION

N. C. ALCOHOLIC REHABILITATION CENTER



BUTNER, N. C.

About the Center . . .

The A.R.C., as it has come to be known, is a 50 bed in-residence treatment facility for problem drinkers. Located at Butner, N. C., a small community approximately 12 miles north of Durham, N. C. off Highway 15, it is operated under the authority of the N. C. Department of Mental Health. The Center provides residence, treatment and workshop facilities for 38 male and 12 female patients.

A.R.C. Treatment Methods . . .

Treatment is by psychotherapy and consists of group discussions led by the professional staff, educational films, individual consultations with staff members, vocational guidance, recreation, rest, proper food and prescribed medications.

Length of Stay . . .

The basic treatment program is based on a 28-day schedule. The patient may remain for a longer period if, in the opinion of the staff, it will be of further therapeutic benefit to him. No applications for less than 28 days are accepted.

Admission Requirements . . .

1. Persons desiring admission must come voluntarily. No one can be admitted by court order. The individual who is sincere in wanting help and who comes voluntarily stands a much better chance of successful rehabilitation.

2. An appointment for admission is obtained by written or telephone application to the Admitting Officer, 406 Central Ave., Butner, N. C. (telephone 919 985-6770). All appointments are confirmed by mail. Preferably they should be made through a physician or other professional person in the prospective patient's community.

3. Since the Center is not designed, nor equipped, as a sobering up facility, the prospective patient must not have taken any alcoholic beverages for at least 72 hours prior to admission.

4. A report of a recent physicial examination by a duly licensed physician must be presented prior to or at the time of admission. The prospective patient's physical condition must be reasonably good enough to enable him to participate fully in all phases of the treatment program. There are no medical beds for the treatment of serious physical or mental disorders.

5. A fee of $75 in cash or certified check only must be paid at the time of admission. No personal checks can be accepted! Cases of true indigency must present written evidence in the form of a letter from their county welfare department at the time of admission or before.

6. A social history, compiled by a trained social worker in the local welfare or family service agency or other professional organization is required. Arrangements for the history should be made early enough so that it reaches the Center within a week following admission.

Admitting Days . . .

In order to facilitate the program of treatment by the small group method, prospective patients are admitted on Wednesdays, Thursdays and Fridays from 8 to 12 a.m. and 1 to 5 p.m. In this manner several days of adjustment to the life of the Center are provided before the beginning of the intensive treatment program the following Monday.

ALCOHOLIC REHABILITATION PROGRAM

OF THE

NORTH CAROLINA DEPARTMENT OF MENTAL HEALTH

NORBERT L. KELLY, Ph.D.
Associate Director

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INVENTORY

VOLUME 15 NUMBER 3

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RALEIGH, N. C.

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THIRTY years ago a person was considered either **sane,** and allowed the conventional freedoms of society, or **insane,** and confined to a sanitarium or asylum. Much has transpired during the past three decades to change that "medieval concept" of sanity.

Today, mental illness is openly discussed and generally accepted. Research and treatment techniques have eliminated confinement as the only "cure" or "solution" for this dreaded illness. Outpatient clinics, day-care hospitals, and short-term hospitalization are alleviating human misery and returning useful men and women to their rightful place in society. Evaluation centers and diagnostic clinics are detecting mental problems in their early stages, because the public has become aware of the common occurrence of this "uncommon" illness. Even so-called incurable and hopeless cases, approached with more humane and diversified approaches, are viewed sympathetically rather than fearfully, with even alleviation, arrest, or cure obtained in many such cases.

In general, mental illness is accepted by the medical profession for what it is —an illness. It is accepted, too, totally or partially, enthusiastically or mediocrely, by both victims and their families, many of whom even boast of visits to their psychiatrist or analyst.

What then about alcoholism? Can we hope to eradicate the ill-founded stigma attached to the illness by the coinage of a new term which would be less connotative, less repelling, and more acceptable?

Alcoholism, the term presently used to denote the progressive illness, marked by uncontrolled drinking which adversely affects one or more departments of life (social, physical, mental, economic, spiritual, etc.), evolved from a multitude of expressions used over the centuries. It replaced "inebriety," "drunkenness," "the curse," and many other expressions used to denote the illness "everyone hates but few understand."

The first known official record of the use of the word "alcoholism" is found in a German reference attributed to Magnus Huss who used the term "alcoholismus" in 1852. The expression "alcoholism" to denote a medical problem associated with the use of alcohol was attributed to Huss in 1860. In the History of Medicine, Huss is classified as a "clinician of note," interpreted as meaning a physician who was best known and recognized for his study of typhoid and alcoholism.

Mention of the term "alcoholism" is found in the Reference Medical Journal of 1877, in the medical literature of the 1879's, and appears in the Medical Temperance Journal.

There have been arguments that "alcoholism" is not the most appropriate term for the illness in question. It has, for one thing, the connotation that alcohol

The symptom makes the illness recognizable.

A New Name for Alcoholism?

BY ASHTON BRISOLARA, M.Ed.

EXECUTIVE DIRECTOR
COMMITTEE ON ALCOHOLISM FOR GREATER NEW ORLEANS

is the root of the problem, which, of course, it is not. Again it carries all of the attached misconceptions of the beverage, and the shameful embarrassment associated with its abuse.

So, over the years, there have been suggestions made to change the term alcoholism to some **ism, neurosis, psychosis, addiction,** or other camouflaged name to make the illness more fashionable, more acceptable, and hence more detectable, and treatable.

In a recent article published in the March 1965 Medical Times, Manhasset, New York, by Michael Shenkman, M.D., it was suggested that "there could not be a better way to perpetuate the memory of this internationally known man (E. M. Jellinek) than by replacing **Alcoholism** with the name **Jellinek's Disease.** By doing so, not only justice would be done in honoring a great scientist, but also the cause itself for which he dedicated his life would be enhanced and dignified . . . and so Cain's brand will gradually fade away from all those affected of Jellinek's disease."

Doubtless no more fitting label could be chosen than "Jellinek's Disease," if ever a substitution is made. No individual has contributed more to the "disease concept of alcoholism" than E. M. Jellinek. It would be a just tribute to a great and humble scientist.

It may sound like a remark from "the devil's advocate" but will any change of identification further the acceptance of alcoholism by the medical profession, the family, the public, or the alcoholic?

Medically, it is only of recent date, 1956, that alcoholism has been officially recognized by the American Medical Association as a disease to be considered and treated accordingly. Would a new name for an old problem really assist the physician to deal more sympathetically and therapeutically with the complexities of alcoholism? Would it lessen even minutely the age-old frustrations? It would certainly in no way offer a "miracle pill" or "cure". Until such time as theories of etiology are established facts, the various therapists will of necessity be forced to continue to utilize the team approach to the problem.

What about the **public** and specifically the **family** of the alcoholic? In defining and promulgating any other concept, or term, would there not be a dual problem encountered? First the impregnating of the newly coined term will have to include some mentioning of excessive, uncontrolled, or addictive drinking of alcoholic beverages, if any type of general diagnosis is to be attained. Hence, there would necessitate the education of term as well as the symptoms, which, though perhaps watered down, only reverts to problems related to the use of alcohol one way or the other.

". . . Advances have been, and are being, made."

Changing the term would only tend to hide the symptom which makes the illness recognizable. The concealing of the symptom might only afford another rationalization device to the **alcoholic** who already is a past master at denial. So there appears to be very little value of a change of term as far as the alcoholic is concerned.

That alcoholism is not as yet generally accepted as an illness or at least as a respectable illness is a matter of record. Few hospitals accept alcoholics under the diagnosis of alcoholism, few doctors treat alcoholics either at home or in the office, many religious denominations oppose the disease concept of alcoholism, employment applications discriminate against the alcoholic by denying him employment, many industries solve their "alcoholic" problems by a routine termination of employment, and in general alcoholics are hidden by families.

(Continued on page 28)

Editor's note: The Zip Code Drive as well as the plea to North Carolina Folk to write us has resulted in some interesting comment about *Inventory* and the uses to which it is put by its readers. Following are excerpts from letters we have received which illustrate some of these uses.

Twelfth Step Work

I have been a member of A.A. for 21 years, so you know that *Inventory* has been a helping hand to me in Twelfth Step work.

Anonymous
Melrose, Massachusetts

Nursing Program

Would you please place us on your mailing list for *Inventory* and such other materials as we may use in our Associate Degree Nursing Program.

Mrs. Regina Schendler, R.N.
Sandhills Community College
Southern Pines, North Carolina

Public Welfare Programs

We have found *Inventory* extremely valuable to our welfare workers who are constantly working with alcoholism problems. Our department also has an active A.A. group which meets in our building.

R. W. Fink, Personnel Officer II
Milwaukee Co. Dept. of Public Welfare
Milwaukee, Wisconsin

Alcoholism Treatment

I would like to be placed on your mailing list to receive *Inventory*. In continuing to seek new approaches to the total treatment of alcoholism, any ideas and information will be of great help to all of us here.

Bartel Frauendorfer, Social Worker
John Umstead Hospital
Butner, North Carolina

City Commission

I just saw a copy of the July-August, 1965, *Inventory* in which there are articles relative to the Miami court program. Would it be asking too much to send me a half-dozen copies which I can distribute to our City Commission? If I or my Court can be of any service to the program in North Carolina, please do not hesitate to call upon me.

Milton A. Friedman, Senior Judge
Municipal Court
City of Miami, Florida

Spreading the Word

Could we have five copies of the July-August, 1965, *Inventory*? One of our projects of which we are very proud is given excellent coverage in this issue, and we want to send a copy to our national association.

Mrs. M. P. Bailey, Executive Secretary
Pitt County Mental Health Association
Greenville, North Carolina

A. A. Discussions

Many an A.A. group meeting here has had as its subject for discussion an article from *Inventory* or even a sentence taken from an article.

Anonymous
Dublin, Ireland

Putting Knowledge to Use

I certainly want to keep abreast of the latest knowledge and insights which *Inventory* offers its readers. It was a great help to me as a seminary student. Now, as an ordained clergyman, I can put this knowledge to use.

Rev. W. J. Jay
Bonnyville, Alberta
Canada

Personal Help

Please send *Inventory* to me. Maybe there will be something in it to encourage my husband who is an alcoholic to seek help and to help me understand alcoholism.

Anonymous
Butner, North Carolina

Court Program

Inventory is read and used by all of us in the court. If you can give us six extra copies, we shall make good use of them.

Mrs. L. P. Tyler
Director of Probation Services
Wake County Domestic Relations
and Juvenile Court
Raleigh, North Carolina

VOL. 15, NO. 3 INVENTORY SEPT.-OCT., 1965

ARTICLES AND FEATURES OF INTEREST ON ALCOHOL AND ALCOHOLISM

Individuals are motivated to reexamine, question and modify their approach in seeking durable solutions to life.

A RELIGIOUS DISCUSSION GROUP FOR ALCOHOLICS

BY THE REV. ENNO K. LOHRMANN

Reprinted by permission from the May, 1963, issue of *The Maryland Review on Alcoholism,* a former publication of the Maryland State Department of Health. The author, who is a chaplain at Spring Grove State Hospital, Catonsville, Md., wrote in a recent letter: "Since this article was written, we have initiated a clinical pastoral training program at Spring Grove for seminarians and community clergy and an advanced program for chaplain residents. Selected students rotate through the alcoholic unit for several weeks at a time as part of their clinical training, and consider it to be a very valuable adjunct to their training experience. We do continue to conduct the described religious discussions with the patients in the unit, and I feel it is still a facet of their rehabilitation which they look forward to weekly with anticipation."

THE Religious Discussion Group in our Alcoholic Rehabilitation Unit at Spring Grove State Hospital has now met weekly for three and one-half years. From a rather shaky, uncertain beginning this group has become an established part of the treatment program.

As the Protestant Chaplain at Spring Grove State Hospital I began visiting the alcoholic rehabilitation unit weekly from the time that it was established in August, 1959. The psychiatrist who organized the unit had returned from the Yale Summer School of Alcohol Studies and was determined to initiate an inter-disciplinary treatment program. He encouraged me to include a group meeting in my weekly visit to the unit. In spite of my limited experience and lack of knowledge about group dynamics at that time, with as much courage as I could muster I invited the men in the alcoholic unit to a weekly religious discussion group meeting which I consented to lead. To my surprise they came, and they have continued to come each week. After three and one-half years of these weekly group meetings, I feel that many patients look forward to our group discussions and that many come away from them with a deeper awareness of the significance which our religious faith can have.

It should be stated that the alcoholic unit at Spring Grove State Hospital has a capacity of seventy male patients. Female alcoholics (average number of six to ten at

one time) are housed in a nearby cottage and are encouraged to attend all activities in the male unit. The treatment plan is for a patient to remain in the rehabilitation unit from four to six weeks after he has "dried out." He is then paroled from the unit for one year or given an outright discharge. Persons admitted to the unit are urged to come in under the "Voluntary Treatment Agreement" and nearly 75 per cent are admitted with two doctors' certificates and about 10 per cent by court order.

In addition to the weekly religious discussion group meeting led by the chaplain, the treatment program in the unit includes weekly group meetings by the psychiatrist in charge of the unit, the research psychologist, the social worker and organizations from the community such as Alcoholics Anonymous and the Flynn Homes.

Which religious questions are relevant in a discussion group with alcoholics? We know that the members of A.A. think of their twelve steps as a spiritual program for the alcoholic. The problem of material to cover in a discussion group is one of communication, it seems to me. Communication becomes more possible when the material meets a relevant need of the individual. Thus, the original plan for this religious discussion group was to focus on the cluster of familial problems which every alcoholic experiences to a greater or lesser degree. Problems of marital harmony and discord, the economic and social bankruptcy which every alcoholic knows from first-hand experience, we felt, would best serve as a springboard for a clergyman to move into dialogue with the alcoholic. It is axiomatic that homes from which alcoholics come are troubled homes. The psychiatrist in charge of the unit felt that the clergyman, perhaps more effectively than a member of another profession, can reopen for discussion these painful problems of disrupted and broken familial relationships.

The discussions proceed from t

While the basis for focusing religious discussions with alcoholics has considerable merit, I now feel that it is too limiting for best effectiveness. I now feel a broader base is needed from which to operate in these discussions.

Some of the religious topics which I feel hold particular interest for the alcoholic and which have involved a large number of group participants again and again include the following:

1. What is God-pleasing love? More specifically, does God still love me in my present miserable condition? Is it possible for an alcoholic to become more of a loving person than he has exhibited in past relationships? Examine the meaning of this sentence, "The greatest test of love is sacrifice."

2. What do we mean when we say, "God forgives?" Can an alcoholic be forgiven?

3. How does the alcoholic build attitudes which will be positive and strong enough to maintain sobriety after discharge from the hospital?

4. What is meant by the statement, "God answers Prayers?" What function can prayer play in the life of an alcoholic?

5. What are the ingredients which go into harmonious interpersonal relationships? Examine the meaning of the Ten Commandments, especially Commandments four through ten.

6. Is there any relationship between religion and psychiatry and psychology? What can a psychiatrist ("head shrinker") do for an alcoholic anyway? "We're not insane."

7. How does "Faith in God" help a person with his conflicts, problems, and anxieties? What does it mean to "have faith?" How can an alcoholic develop a mature faith?

8. What do people get out of going to church? Let us examine why many

alcoholics have stopped going to church regularly? It is possible—or desirable—to make an effort to start going back to church?

9. Will "people outside" accept an alcoholic after he has been in a rehabilitation unit such as this?

These are some of the questions which I note continue to reoccur in our discussions. We could list more, but my purpose here is not to present an exhaustive list of topics for discussion but rather to emphasize that alcoholics do have religious concerns and to describe the kind of religious concerns which they have.

Later I propose to state something of my philosophy as a group work leader. It is appropriate to state here, however, that I do not consider my function as leader to attempt to provide direct descriptive answers to the problems under discussion with the group. I consider ours to be a clinically-oriented, problem-centered religious discussion group. As such, it is our function to proceed from the feelings and experiences which the participants verbalize about religion or past religious involvements. I see my role as clergyman leader to be first of all one who serves as a catalyst, one who gets the participant involved in the issue at hand. To that end, I seek to establish an atmosphere of acceptance of the individual participant as a person. Insofar as I am successful in accomplishing this, I can question, interpret, or challenge what a given person says.

The worth of a given group discussion with alcoholics is measured then, I feel, by the extent and level of the involvement (verbal and non-verbal) of the participants. In this group my didactic role remains subservient to the role of catalyst. I shall seek to differentiate between the various functions of the leader of a religious discussion group later.

Usually our group meets in the day room of the alcoholic unit with everyone seated in a circle. Very often a "special chair" is placed for me to use. I usually sit near but not in the "seat of honor." I seek to emphasize continuously that while I am the admitted leader of the group I am also a part of the group. I open the meeting by saying:

"Our purpose during this hour is to share with one another the meaning which our religious faith has or has not had for us and to explore the meaning which it can have for us in the future. It is not my plan or purpose at this meeting to give you a lecture or sermon on religion. We are here to help and to learn from one another. Now does anyone have a problem, question, or situation which you wish to share with us to start our discussion?"

In many of the meetings someone will initiate our discussion by presenting a personal problem or asking a question which then serves as the springboard from which we launch into our discussion. When no one responds I suggest a topic or a question which may serve to introduce our discussion. Occasionally I will present a five minute summary of a recent sermon which will raise questions in the minds of the participants.

In this presentation I have chosen to describe one of our meetings in the alcoholic unit which was held in 1962. I suggested that we use the story of the Prodigal Son, Luke 15, as the basis for our discussion with the general theme, "Our Relationship to God."

After reading the story aloud to the group, I suggested that we begin by thinking back to the days when we came to the age of independence, the years of our lives between sixteen and twenty. "Is there anyone here who sees any similarity in your relationship to your father during those years to that which

(Continued on page 10)

ZIP CODE NOTICE: Many thanks to those of you who have sent in your zip code number. The numbers are being processed and should appear on the address labels soon. If you have not sent in your zip code number, please do so at your earliest convenience. Although there is time for a gradual changeover, the Post Office Department has ruled that the mailing address of each subscriber must show the zip code number. Eventually, therefore, addresses without the zip code number will have to be deleted from the mailing list. Just send a post card with this information to: INVENTORY, Box 9494, Raleigh, N. C. 27603.

TREATMENT FOR FIRST OFFENDERS: The Baltimore Area Council on Alcoholism reports that a probation officer has been assigned an office in the Eastern Health Clinic, Baltimore, for the purpose of offering treatment to first offenders whose offenses involved drinking or intoxication. First offenders will be on probation and must report weekly to meetings held by the probation officer. At these weekly meetings, representatives of various treatment resources such as Alcoholics Anonymous and alcoholism clinics will explain their programs and offer help to the probationers. Pastoral counseling also will be available. The program was made possible through the cooperation of Paul C. Wolman, chief of the State Department of Probation and Parole.

GOLDSBORO, N. C.: Four in-service training sessions on alcoholism for nurses and attendants of Cherry Hospital will be conducted October 15 and 29 and November 5 and 10, 1965

PUBLIC HEALTH NURSES: Public health nurses of northeastern North Carolina have begun participation in an in-service training program on mental illness and alcoholism. The program consists of a series of seven sessions to be held on the first Monday of each month from October of 1965 through April of 1966. Each session will consist of a one-hour lecture followed by a one and one-half hour discussion period. There will be four sessions on mental illness, two on alcoholism, and a final summary session. The chief interests are diagnosis and treatment, and the topics, in order of presentation, are: Trends in Organization for Treatment of the Mentally Ill, Alcoholism, Alcoholics Anonymous and Al-Anon, The Neuroses, The Psychoses, The Aging, and the summary session. The lecturers will be drawn from the mental hospital system, including John Umstead and Cherry Hospitals and the Education Division of the N. C. Department of Mental Health. The final session will take place at Cherry Hospital, Goldsboro. All others will be conducted at Hertford, N. C., in the auditorium of the Agricultural Building.

IOWA LEGISLATURE PASSES HISTORIC BILL: The Iowa Legislature, by a Senate vote of 53 to 0 and a House vote of 106 to 1, has passed a bill providing that persons convicted of a second or third drunken-driving offense may be committed for treatment of alcoholism to a hospital instead of a 1 to 5 year term in the penitentiary as under the old law.

Basically the thinking behind this new legislation, according to Charles A. Churan, executive director of the Iowa State Commission on Alcoholism, is that alcoholism is a treatable illness as declared by the American Medical Association in 1956. It allows the court to make a distinction between a common drunkard and a true compulsive drinker. It assumes that no one having experienced a drunken-driving conviction and knowing the penalties would risk another conviction unless he were, in fact, a compulsive drinker. "Looking ahead," he said, "the number of drunken-driving convictions could well prove to be a safe and just measure of whether the offender is an alcoholic or not. After the first conviction, even the heavy 'spree' drinker will limit his alcohol intake when he drives, but the alcoholic will not."

This action of the Iowa Legislature may prove a historic landmark in the legal concept of problem drinking and set a courageous example for the entire nation to follow. "Not only is our legal viewpoint catching up with our medical viewpoint," Churan said, "our courts of tomorrow may recognize compulsive drinking as an illness and the compulsive drinker as a sick person."

SANFORD, N. C.: "Emphasis—Humanity" was the theme of the 1965 Employees' Field Day of the N. C. Prison Department held September 10-11 at the Personnel Training Center. The event commemorated efforts of prison employees throughout the year to bring about improvements in custody, rehabilitation and treatment programs, and awarded personal and group achievement through contests at the Field Day Exercises. In the area of Booth competition, all but two of the 22 displays exhibited by the prison institutions and divisions emphasized alcoholic rehabilitation efforts. Alcoholic rehabilitation was the only theme of the first and second place winners, the 6th and 8th Prison Divisions, respectively. The second place winner, constructed at the Caldwell County Unit of the 8th division, is shown below. The first place winner was constructed at the Forsyth County Unit of the 6th division.

Second Place Winner
Booth Competition

1965
Employees' Field Day
of the
N. C.
Prison Department

Exhibited by
The 8th Division

Prison Department
Photo
By Hal Rericha

the Prodigal Son had with his father?" I suggested that we begin with the person on my left and ask each person in the group to comment. It was revealing to me to hear that nearly half of the twenty-four persons present reported that at the age of sixteen they were not living at home with their father. Upon closer inquiry I learned that ten of the twenty-four alcoholics present in that group had not lived under the same roof with both father and mother during the first twelve years of life. The brokenness of the interpersonal relationships in the life of the alcoholic became graphically clear to me at the meeting.

Most alcoholics see a striking similarity between the experiences of the Prodigal Son and their own. Nevertheless, each person benefits from relating the distinctive characteristics of his situation. "I am like him (Prodigal) . . . . only when I am down and out will I ask for help." "I see considerable similarity between myself and the older brother in the story — self-satisfied, self-sufficient." ". . . . many of us have made alcohol our God; we have wandered into a far country and need to turn back." ". . . . if only I could change my attitude like the Prodigal Son did, and make it stick. I can 'go back on bended knee' but I'm afraid I can't make it last." One alcoholic patient saw a similarity in the rejection of the older brother for his younger brother and the rejection which alcoholics experience in the community as they seek to move out of the hospital.

At this particular meeting I spent the last five minutes summarizing what had been said and added comments of my own stressing the symbolism of this story. The father in the story represents our Heavenly Father. Each of us strays from his father's loving care. When we return, it is important that we do not confuse the jealousy of the older brother with the loving acceptance of our Father (God). The conflicting voices are ever present with us. On the one hand we hear the Father, "I know that you have slipped; I am willing to accept you again —not seven times but seventy times seven." Meanwhile, the voice of the older brother (our fellowmen) is shouting, "What is this drunken bum doing back here? . . . don't let him into my house. I won't have any more of him." Let us ever be grateful that forgiveness is dependent upon the eternal love of God rather than on the caprice of men. Would that we could fully capture the deeper significance of that truth. With this conclusion I noted that our time was up and adjourned the meeting.

What meaning do religious group discussions have for alcoholics? Thus far I have not attempted a systematic study of the various responses which participants in as large a group as this would make. However, I have noted the observations of alcoholics who have attended the discussion group and have been active participants in our group. I also consider these responses to represent a cross section of the kind of help which the participants feel they receive from a group such as ours:

Meaning to Patients

1. "Meetings such as this provide me with an opportunity to rethink serious questions about life which I have long ignored."

2. "It is helpful for me to exchange ideas about religion and God with persons who have experienced similar problems to mine."

3. "After our meeting tonight I feel that I will be able to manage another twenty-four hours of sobriety."

4. "I am looking for guidance. If I had learned more about God and my religious faith sooner, I don't think I would be here. I want to learn more about what works and what doesn't work in people's lives. All I know is what hasn't worked for me . . ."

In summary permit me to briefly state what I see to be the function of our

religious discussion group described in this paper and how I view my role as leader. I recognize at least four different objectives of our group, and as leader I must be aware of each objective so that I may use the approach best suited for a given situation.

1. **Objective one:** The religious discussion group provides an opportunity for the patient to express what he has experienced, what he feels, and what he has come to believe about God through past and present involvement. To meet this objective it becomes my task as leader to strive to create an atmosphere of acceptance and concern for each individual as a person. I seek to involve group participants by whatever means may be available. I may comment or remain silent, interpret, challenge, question or elaborate on what has been said. I see myself using an eclectic approach. My understanding of the group situation determines my response to that situation.

2. **Objective two:** The religious discussion group provides an opportunity for alcoholics to relate to one another as children of God. It provides a platform from which each individual can speak if he will, and he will be heard. To that end I, as the group leader, would seek to help each person individually, and the group collectively, to realize that in the midst of loneliness they do not stand alone. I would reassure each person (more nonverbally than verbally) that in the midst of tribulation and suffering he still has an identity with a large family of sufferers who are of the Household of Faith. All of us enter into God's Kingdom through much suffering. I would seek to cultivate the feeling that it isn't what has happened to you that matters as much as how you feel about and what you do about that which has happened to you. We may not know the answers to specific problems; yet each of us needs to feel that we could do something about them sooner or later. All of us needs to experience a sense of hope.

3. **Objective three:** The religious discussion group provides an additional opportunity for each patient to become more aware of the complexity of the personal and psychological factors of behavior which are constantly operating in interpersonal relationships. While this might be a primary objective of group therapy led by a psychiatrist, it seems to me that this is also an important objective of all groups meeting in a hospital setting. To that end I as a group leader would seek to help participants realize more fully and accept that what we now are is largely the result of interpersonal successes and failures of our past lives. To that end I may serve as an interpreter of behavior, a teacher, or a counselor. To the extent that patients are able to verbalize and accept successes and failures of their past relationships they can move forward to a more satisfying life adjustment.

4. **Objective four:** The religious discussion group provides the participant with the opportunity to develop or to update his philosophy of life so that he can lay the groundwork for choosing how he can live most helpfully with others either in or out of the hospital. As the leader of the group who is a clergyman I see myself serving here as a catalyst for the patient. I see the group experience serving to deal with one person's concern to help all who participate. As one person in the group dares to appraise his personal involvement in life, or lack of it, others in the group are helped to face life more realistically. As one participant starts over again, others in the group gain the courage to try again.

After three and one-half years of leading a religious group discussion in our alcoholic unit at Spring Grove State Hospital, I feel confident that individuals in our group are motivated to reexamine, to redefine, to challenge, to question and to modify their approach in seeking durable solutions to life. It is our hope that this will continue to be true.

The Clergy and Alcoholism

BY E. A. VERDERY, D.D.

Reprinted by permission from *Lifelines,* published by the South Carolina Alcoholic Rehabilitation Program. Dr. Verdery is director of the Department of Pastoral Services, Georgia Baptist Hospital, Atlanta, Georgia.

AS ministers we have often overlooked the alcoholic's real feelings in the struggle and perplexities of life. Among the diverse feelings which characterize the alcoholic, the minister may relate especially to his sense of isolation, to his dependency needs, to his guilt, and to his sense of purposelessness in life.

Although the alcoholic frequently appears to be a gregarious, affable and extroverted individual who does not have a care in the world, experience reveals he often feels lonely, unconfident, and insecure. Then, he drinks with the conscious or unconscious awareness that he will not always feel alone and unpopular for he will create an imaginary situation in which he is what he wishes he really could be. One patient expresses it like this: "I feel I was never wanted by my family. This preys on my mind all the time and I can do nothing about it. I feel so alone! But when I drink a little I can forget . . . at least for a while." Is it any wonder that, in her search for a sense of belonging, this female patient has experienced multiple marriages, always feeling that somewhere, somehow she will experience real closeness?

The alcoholic feels more dependent on outside forces and persons than upon the resources within himself. One recovered alcoholic describes vividly this strong dependency in saying: "When a person is in the midst of his alcoholic disease, he feels that the world is a breast for him alone to suck on." In this connection, Dr. James A. Knight, Tulane Medical School professor, relates having treated an alcoholic who had tatooed under one breast "sweet" and under the other "sour." This describes vividly how he felt the world had fed him. "It seems," Dr. Knight concludes, "that his mother, his wife, and most of the women in his life had always given him sour milk and he wanted to immortalize them by this symbol under his left breast. Then, he had found that the only source of sweet, dependable, high quality milk was in the bottle of alcohol."

The guilt and self-rejection which the alcoholic feels sometimes lead to an act of suicide. However, if the act of suicide is performed by only a small percentage, an attenuated form of suicide is committed by the alcoholic as he continues to drink compulsively day after day. Obviously, any person who punishes his body so relentlessly must have deep unrest and need for self-destruction.

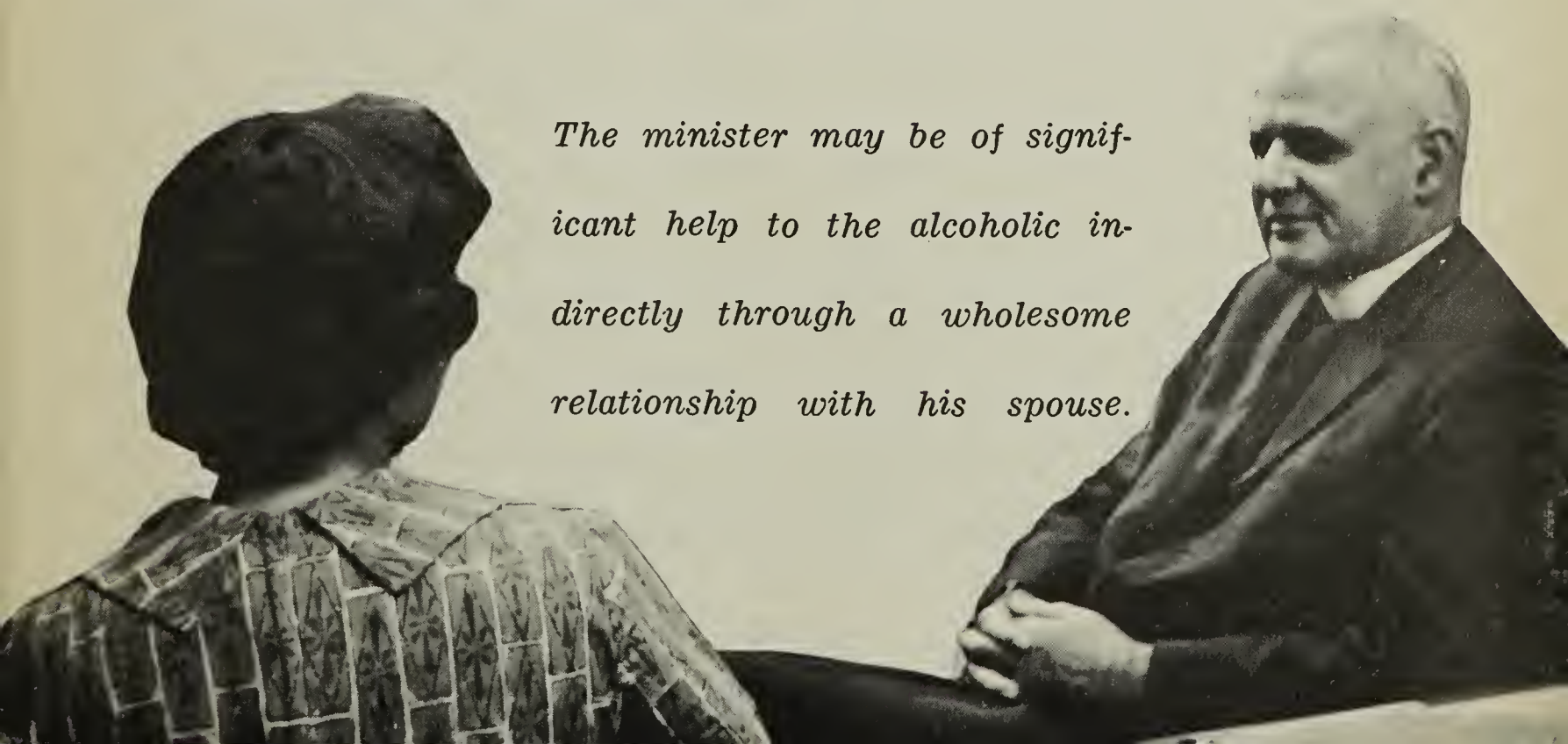
Theologian Paul Tillich considers a sense of purposelessness or meaninglessness in life as an emotion

indigenous to human existence, and it is recognized as a dominant feeling with a great many alcoholics. This "treadmill" existence, as Lewis Sherrill calls it, is described in the patient's despairing cry: "I have no reason to live. Life has no purpose any more." The question naturally arises whether there was ever real purpose and meaning in life and, so, why was it necessary to drink to change it so completely? As one works with the alcoholic, he is reminded of Voltaire's despair: "I hate life but I'm afraid to die." This is the dilemma of many an alcoholic until he discovers a uniqueness and a sense of particularity about his own life. Buber sees this effected in an "I-Thou" relationship in life, one which many alcoholics have discovered in a therapeutic community. The early Christian church was described as a community in which "they loved one another." It is not uncommon to hear patients in treatment say that they have now realized for the first time what it means to be respected and loved.

Love makes demands, and many alcoholics have never experienced the demands of love but have been badgered with the demands of conformity and social expectations. Therefore, the firm, strong demands of love, when genuinely felt and not watered down in pious, empty clichés of superficial acceptance and overprotection, strengthen and inspire the alcoholic for new conquests within his spirit and in the world about him.

It is impossible to understand the alcoholic apart from his family and his surroundings. Effective treatment of alcoholics frequently involves the alcoholic's relatives, particularly the spouse. In many instances the initial contact with the minister is not with the patient but with his spouse. Moreover, the minister may never be directly in touch with the alcoholic, but may be of significant help to him by virtue of a wholesome relationship established with the alcoholic's marriage partner. To this mate, the clergyman may be a confessor, a sounding board, or even the object of unmerited hostility. If the pastor can be so related to the spouse, he may help the spouse regain hope, to consider what the alcoholic's drinking really means to this spouse, and to begin looking at her own emotional and spiritual needs.

Treatment centers for alcoholics have discovered that many times alcoholics do not gain sobriety until the spouse becomes involved in treatment. Therefore, family discussion



The minister may be of significant help to the alcoholic indirectly through a wholesome relationship with his spouse.

groups are made available to relatives of alcoholics. Frequently the patient's wife (or husband) will observe: "I know I would not have been able to help my husband (or wife) if I had not had these meetings to talk about my feelings too. We just couldn't have made it if he had changed and I hadn't." Another wife concluded recently: "I first came to the clinic because I thought he needed me to come to give him support and encouragement, but now I see I needed it as much as he did if not even more." The experiences of therapists substantiate the psychological studies which reflect that the spouse of an alcoholic is quite often disturbed emotionally and that the disturbance was pre-existent to the onset of alcoholism.

If one is to understand how family relationships participate in the causation and continuation of the drinking pattern, one must reexamine the role each person plays in the home. Often the usual male and female role is confused, even sometimes reversed, in homes where alcoholism is evident. The wife of the alcoholic may be related to the husband more as a mother than as a mate, and she may be much more dominating and overprotective than his mother or father.

Such a case is that of a woman who is married to a man five years her junior. She was successful in business, had a home left to her by a deceased husband, and a new, expensive car; but she had no children. This alcoholic husband had been married previously and was divorced. He had returned to his parents' home following his divorce and had worked in his father's business when he was not drunk. His father repeatedly got his son out of jail while he lived in his house, but welcomed the son's second marriage, hoping this would be a solution to the drinking. After the marriage, the wife continued to work and began to pay him out of jail as had his father. He ceased to report to work more frequently, drove his wife's car, disappeared for days and was often found by her in hotels with other women. His wife continued to take him back home, prepare his meals, care for his clothes in a meticulous manner, and cajole him "to be a man." She, like her husband, would attend an occasional A.A. meeting, but she could not maintain regularity there. When attending clinic group meetings, each remained defensive and dependent. When either experienced any form of confrontation in the group, he would have to withdraw.

Later each became interested in a neighborhood church and, after a religious experience, became members there. For some six months this seemed to put things in better order in the home. Then, without any particular warning to his wife, he left home again. Each time he leaves home to drink, she will locate him, will pack him back home, and then wait on him attentively. Recently, she suffered a heart attack and is unable to work or to continue to pay the bills. In seeking a solution to this dilemma, she is going from one minister to another, but is quite controlling and demanding of advice which might solve the problem. However, she will entertain no suggestion that she can help him in any way except as she always has—to show him she loves him by "being good to him."

It seems self-evident that this alcoholic's wife gets some neurotic satisfaction from such a relationship or else she would not perpetuate the marriage. But, for her to change would be as revolutionary as for him to cease his drinking. To suggest that an automatic reversal of roles would cure the problem would be to

oversimplify a complex situation. One must first understand that the needs which prompted the creation of this marriage must be met in other ways if the marriage is to be maintained.

Having considered the scope of alcoholism, and the alcoholic's feelings, let us now look at the assets of the clergyman in the recovery of the alcoholic.

One of the most significant assets which makes a minister's work effective is his *privileged position* in the community. The pastor is often the first person to whom the alcoholic and his family turn when it becomes evident that drinking has become a problem. This is especially true inasmuch as guilt is almost invariably intertwined with the other discordant emotions the alcoholic and his family feel.

Other Assets

Another asset is that his parishioners can feel they can confer with their pastor without payment of fee which often they may not be able to pay. Although the clergyman may not expect payment in dollars and cents, honesty requires us to admit we wish he would reward us by staying sober and/or becoming an active member of the congregation. Herein, the minister has a lot of room for self-examination lest he tend to exploit the alcoholic as he suspects he may be exploited by him.

A third asset is that of the unequivocal faith of the alcoholic, or of his family, in the minister's ability to help him. Without such faith in the minister many would actually receive no aid, but with it they feel increased confidence. Although the alcoholic may anticipate help from the minister by virtue of his role, the minister soon recognizes that ordination gives him no magical answers. Hiding behind a clerical collar or theological shibboleth soon becomes distasteful to the sincere pastor. Thus, he must come to grips existentially with his own selfhood, with theology as it is lived and experienced, and not simply as it is presented in the theological schools or in textbooks. Again, it must be stated forcibly, the clergyman has himself to give, but only if he has truly come to possess himself so he is able to give himself to others.

The fellowship of the church can never be overlooked as a potential asset in the program of rehabilitation and counseling with alcoholics. Seldom is the ideal realized but wherever true brotherhood is practiced the alcoholic may discover real hope. All alcoholics have a need to feel accepted and often our churches fail to provide this for them. A patient at Georgian Clinic described acceptance when he said when he came into the gates he felt people say, "I understand." Such a spirit can conceivably permeate an entire congregation and if it does a real transformation will take place in the entire community.

In working with alcoholics the minister should not overlook the value of a religious conversion experience. When the conversion experience is a genuine one it aids in the integration of personality and is a psychologically valid phenomenon.

Clinebell states that he feels that "the eventual goal of counseling . . . is referral." However, if one concludes from this observation that the pastor's role is to confer with the family of the alcoholic or the alcoholic himself one time and shuttle him off to someone else, he has missed the point altogether and has underestimated the minister's role. Oftentimes, circumstances permitting, if the minister will establish a relationship with the alcoholic and then

(Continued on page 27)

Allies are not just helpers—they are partners.

Some A.A.'s and some professionals must learn to

share the responsibilities of treating alcoholics.

ALLIES OF ALCOHOLICS

ALCOHOLICS Anonymous and the modern Scientific Approach to alcoholism had their beginnings at about the same time—30 years ago. It was as though "Mother Ethyl" had given birth to twins.

These "children of Ethyl" have led quite different lives. A.A. set about to help alcoholics, while the Scientific Approach set about studying, analyzing, testing and building up a body of knowledge which might eventually be used to conquer alcoholism.

Most A. A. members have felt the need to acquaint physicians, judges, lawyers, clergymen, and the general public with an understanding of A.A. It *is* important for professional people to become acquainted with A.A., and *it is just as important that A.A. members become acquainted with the Professional Approach to alcoholism.*

The Scientific Approach to alcoholism has been a slow approach compared to that of A.A. It began with the collection of knowledge. It built up a large body of new information and it found many answers to the questions it asked. The people who studied man and alcohol were not content to just collect knowledge. They have taught thousands of professional people, who in turn are testing the knowledge in real life problems, and they are just beginning to use the alcoholism knowledge to help alcoholics.

All over United States and Canada there are professionally trained people who have become acquainted with the scientific information about alcoholism, and they have fit it into their own professional skills. There are, today, hundreds of non-alcoholics who are devoting full-time to meeting the problems of alcoholism. There are good educators, good physicians, good psychiatrists, good clergymen, good administrators, and good social workers working in alcoholism treatment centers, alcoholism information centers, and in hospitals. There are, in our countries, thousands of professionally trained people who include alcoholics along with other sick people in their clientele.

These allies of A.A. are not as effective as A.A. in terms of the numbers of their successes. Their skills with alcoholics are not as well tested as are A.A. skills, but they have not been working at it as long as A.A. has worked. Their experiences will improve with time and their successes will improve with time.

Alcoholics Anonymous and the allies in the professional fields have had an interesting effect on each oth-

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NONYMOUS

This article is based on a speech presented by the author at the 30th Anniversary International Convention of Alcoholics Anonymous at Toronto, Ontario, Canada, in July of 1965. Though planned for members of the fellowship of A.A., the article contains challenging ideas for all people who are concerned about alcoholism.

er. There has been no alliance and no formal affiliation between these two children of Ethyl, but each has helped the other in subtle, but effective, ways. While science was developing knowledge about alcoholism, A. A. was developing dramatic proof for the need of knowledge, and for the human and economic rewards that are available when the knowledge is fully working. A.A. supplied for society the proof that helping alcoholics is a worthwhile and profitable thing to do. The tax money that goes to support alcoholism education, research and treatment, goes there partly because A.A. has demonstrated the values of helping alcoholics, and partly because professional people were willing to devote their skills and knowledge to establishing alcoholism programs. The Community Chest money and the private monies that go into alcoholism programs stand as a testimony to the faith of the donators that alcoholism is a treatable illness, and A.A. has had a big part in creating that faith by demonstrating that alcoholics are not hopeless.

If it were not for A.A., the Professional Approach to alcoholism would be an isolated, poorly financed, uncoordinated, sporadic dream that was a century away from helping anyone. A.A. is the sunshine that has warmed the soil and made possible the growth of allies in the professional fields.

On the other hand, A.A. has profited from the work of its allies. Professional educators have done much to make people aware that alcoholism is a respectable disease, and this knowledge has helped many alcoholics to admit that they, too, are powerless over alcohol. Members of the helping professions, aware of the incompleteness of their own therapies, have introduced thousands of new members to the A.A. fellowship. The followers of the Scientific Approach have done much to open the doors of court chambers, personnel offices and hospitals, and many A.A. members have found help with twelfth step work because these doors were opened. The Scientific Approaches have done much to establish alcoholism as a respectable illness and they will do more.

Much knowledge about alcoholism has been gained from studies involving alcoholics who are recovering from the illness. Here, many members of the fellowship have worked with scientific resources to produce information of value to both.

A.A. and the Scientific Approach have not always loved each other like brothers. Many times they have quarreled like brothers.

Professionals have looked at A.A. and have said, "You gain your sobriety but you don't know what to do with it when you get it." There is some truth in this statement, but it

applies to A.A. extremists and not the average A.A. member.

Some have looked at A.A. and said, "Sobriety should be a method whereby an alcoholic can live a full life, but you have made sobriety a major goal in life and you spend your lives as though society expects nothing more from you than just being sober." This is true of some A.A. members, but it applies to extremists and not the average member.

Some professionals have looked at A.A. and said, "Alcoholism is a straight jacket that prevents man from normal living, and A.A. is made up of people who live in a 'nut house' bragging about the way they escaped from the straight jacket." This observation is not without some basis, but it applies to extremists and not the average A.A. member.

There are those who have said, "You have made a religious sect out of A.A. and you have sanctified your founders." This is true only of A.A. extremists.

The criticism has been made that members of the fellowship have seen only a small part of the alcoholism problem and still they set themselves up as the only experts. This is a valid criticism of some, but these are the extremists.

Professionals have looked at A.A. and said, "You expect the professionals to be your helpers and to work only with the jobs that you assign to them, and you discourage any treatment that does not fit into your patterns and beliefs." This is just criticism of some, but these are extremists.

Many who have come from the Scientific Approach to work on problems of alcoholism have singled out extremists in A.A. and criticized A.A. as though the whole fellowship is made up of extremists.

Some A.A. members have been equally guilty of generalizing on inadequate evidence. Some have looked on physicians, and social workers, and ministers who have not yet learned to use their skills in helping alcoholics and have said, "Professional people cannot help alcoholics." This may be true of many professional people, but it is not fair to denounce the Professional Approach because some people are not yet effective.

There are some A.A. members who have looked at professional alcoholism workers and have said, "These people think you have to have a college degree in order to help alcoholics and they ignore the successes of A.A." This is true of extremists, but they are extremists.

Some have seen professional people make serious mistakes with alcoholics, and have criticized these mistakes and acted as though the professional therapist does nothing but make mistakes.

A.A. and the Professional Approach have each hurt its own cause and wasted valuable time criticizing the other like two jealous brothers.

So the two children of Mother Ethyl have lived for thirty years both quarreling and helping each other. What lies ahead? Can they expect to go on like this for another thirty years? The obvious answer is, "No."

These changes are probable. 1.) The general public will come to accept alcoholism as an honorable illness. 2.) Scientific knowledge will continue to filter down to the treatment people, and doctors, social workers, and clergymen will become more effective in treating alcoholics. 3.) Employers, law enforcement officers, and judges will come to recognize alcoholism as a respectable illness that causes people to break laws and lose jobs, and they will recognize

that it can be successfully treated. 4.) Alcoholism will be understood as a human problem more like other human problems than we now believe it to be, and alcoholics will be treated more like other sick people.

If these changes do come about, there will arise a pertinent question: "Must A.A. change?" Again there is an obvious answer—"Yes."

The Apostle Paul once wrote, "When I was a child I thought as a child, I spoke as a child, and I understood as a child. Now that I have become a man I have put away childish things."

The two children of Mother Ethyl have thought like children, talked like children, and quarreled like children. It is just about time they became men and put away childish things. Here are some childish games they should quit playing:

Childish Games

Physicians have been playing a game called "Blind Man's Bluff" and many A.A. members have been playing like they were doctors.

Some members of the fellowship have been playing nurses while the real nurses were playing like they didn't see alcoholics.

While the ministers played a game called "Hide the Bottle" some A.A. members were playing like they were preachers.

A.A.'s have played like they were school teachers while the real teachers were playing a game called "Scare the Children."

Employers have played a game called "Pamper, Punish and Fire" while recovering alcoholics played like they were operating employment agencies.

A.A.'s have played like policemen while the real policemen were playing like "drunks" were punching bags in a game called "Crime and Punishment."

Society played a game called "Sweep Them Under the Rug" while A.A. played house maid.

A.A.'s have played a game called "King of the Mountain" where they shoved down any one who challenged their position and trained people played like they didn't have time to treat alcoholics.

Alcoholics Anonymous was born at a time when the people who should have been helping alcoholics were "passing by on the other side," so A.A. stepped in to do the other guy's job. It is high time that the doctors do the doctoring, the nurses do the nursing, the police do the policing, the employers do the employing, the judges do the judging, the preachers do the preaching, the social workers do the social working, and the A.A.'s carry the message of Alcoholics Anonymous.

Perhaps it is not accurate to say, "A.A. must change." It may have been better to say, "Some A.A. members must change the things they do in the name of A.A." A.A. members must accept some changes. Allies of A.A. will eventually provide for alcoholics the same types of treatment they provide for other sick people, and they will provide these services better than A.A. members can provide them. The professionals will never be able to do the total job alone. Each must put away childish games and think, act, and speak like grown-up men.

This does not mean any change in the Twelve Steps, or in the Twelve Traditions. There is no need to change the successful methods of A.A. The whole attitude of our society toward alcoholics is changing ing and A.A. members must adapt to the changing environment.

Thirty years ago the only available help for alcoholics was A.A.

There is something personally satisfying about being a part of the "only hope." Deep down inside people get great comfort from feeling that they are the only ones that can help. It is easy to kid oneself that God gave A.A. total responsibility for helping alcoholics and that anyone else who wants to can be little helpers who help A.A. do its God given task.

Allies are not just helpers—they are partners. Good allies use different methods, they work in different areas, and they use different tools. Many have the common goal of helping alcoholics return to normal lives. None is yet effective with all alcoholics, and each may succeed where others fail. Some A.A. members and some professionals must learn the hard way to share the responsibilities of treating alcoholics.

There is one lesson that both A.A. members and professionals have yet to learn. Neither can truly claim maturity until they learn this lesson.

No one is truly adult until he can stand on his own two feet and speak out loud and clear and say to all men words like these: *"I am a human being, a child of God, and a brother to all other human beings."*

Alcoholics and non-alcoholics have overemphasized their differences, and have failed to recognize that they are more alike than they are different.

In the world today there are struggles between capitalism and communism, because man has not grown up enough to recognize that capitalists and communists as human beings are more alike than they are different.

There are conflicts between labor and management, because neither labor nor management is yet ready to recognize that they are all human beings, and human beings have more similarities than differences.

Alcoholics and non-alcoholic therapists cannot mature until each recognizes that they are more alike than different.

There is conflict between youth and adult, and this will continue to be true until each truly learns that both are human beings and differences are relatively minor.

The communists and the laboring people, and the management people, and alcoholics, and the physicians, and the nurses, and the clergymen, and the social workers, and the rich, and the poor—are all more alike than they are different, and each will remain as little children until they can all stand on their own two feet and say, "I am a human being—and so are you."

Cut any of them and they bleed. Strike any of them and they bruise. Offend any of them and they either strike back or run away. Deny any of them food and clothing and shelter and love and attention and recognition—and they suffer. Take away their air and they die.

All people want the same basic things from life and each must learn that the best way to get what he wants is to join with others to help all mankind get what each human being wants.

It would be foolish to deny that there are differences in human beings. The point is that people must learn to see differences and similarities in their proper relationship.

Strength comes because different people learn to concentrate on their similarities.

The allies of A.A. and the members of A.A. have many differences. They also have many similarities. The two children of Mother Ethyl can be truly mature—just as soon as they recognize that they are more alike than they are different.

The author defines alcoholism as a learned way of life and defends the term "alcoholism" on the basis that it is an accurate generic term for a range of clinical disturbances having one common outstanding symptom.

THE ALCOSES:

"Alcopression and Alcophrenia"

BY NORMAN A. DESROSIERS, M.D.

Dr. Norman A. Desrosiers is director of medical services, West Virginia Department of Mental Health, Charleston, West Va. His philosophies and writings became well known to *Inventory* readers during his tenure as medical director of the Alcoholic Rehabilitation Center at Butner, N. C.

Editor's Note: The author, in this article, denotes the seriousness of the psychological disturbances underlying alcoholism by the collective designation of *the alcoses* and further differentiates two recognizable clinical conditions in terms of their etiologic development and psychodynamic formulations, namely the alcoses of *alcopression* and *alcophrenia*. A second paper on the *alceuroses* has been promised by Dr. Desrosiers at the earliest possible time (no definite date).

ALCOHOLISM is a learned way or philosophy of life, slowly or rapidly developing in a given individual, which includes the constant or intermittent use of a self-prescribed chemical substance to enable that individual to face comfortably the psychological stresses and strains of life.

Although many would like to change the implications of the word alcoholism because it is a generic-type term that implicates alcohol itself as causative agent, it is highly doubtful that this change will occur. The ending, "ism," conveys well the meaning that the individual who makes use of the substance is living a philosophy of life that becomes practically his total way of life. There is good precedent for this view when one thinks of other philosophies of life like Buddhism, Confucianism, Communism, etc. There is at the root of each of these philosophies of life a more-or-less complex set of beliefs and faith standpoints which determine the behavior of the adherents. So it is with alcoholism. But here the philosophy is simpler and the faith is in the unique powers of a simple chemical substance called alcohol.

The simple philosophy is that of Epicurus, namely that one shall at no time in his life suffer or experience for long any unpleasant physical or psychological distress. The faith object, which never fails to deliver instant surcease for many years, is, of course, alcohol—the enslaving deity of the practitioners of this way of life.

By the ingestion of the faith object, alcohol, into their very bodies, do they not reinforce the faith in its power and come to desire that state of its presence therein to become their constant state which, indeed, does come to pass? How very close a parallel one sees in the Nirvana

state of the Buddhistic faith, or the act of communion with the Christ in Christian theology, in the relationship of the devotee of the almost religious-like philosophy of life called alcoholism and the demi-god of their lives, named in the earlier days the "aqua vitae" itself, the very water of life!

No, it appears that the word alcoholism is here to stay. It is too accurate in its broadest connotation as a learned philosophy of life to be challenged seriously. As has been indicated above, there is too much parallelism and established precedent in language, thought and practice to alter basically the meaning of the term. It is a quite accurate word symbol and a good, broad generic term.

What does need clarification, however, are the various doctrines held and practiced by the adherents of this way of life. Although they all have a similar physiologic encounter with the deity, alcohol, they do not all come to be enslaved worshippers by the same route, if at all. Genetic backgrounds, parental influences, disease experiences, school and peer influences, social and cultural pressures are in some measure different and yet they all arrive at the same condition. The understanding of how this occurs and what some of the different routes are deserves our closest scrutiny.

There are sects in the philosophy of life of alcoholism, denominations of imbibers who have their own patterns, and it is our purpose to come to an understanding of the development of these sects. It shall be the purpose of this article to try to name more descriptively—in terms of their most outstanding characteristics—two of the more serious practitioners of this way of life and attempt to justify, by analysis of the underlying psychodynamic factors, the reason for the redefinition of the problem.

Let it quickly be stated that the individual who gets into trouble with alcohol (or any other addicting drug for that matter) is the one who learns well, by repeated usage, that ethyl alcohol is the oldest, most readily available, fastest acting, cheapest, never failing, self-prescribed tranquilizer, antidepressant, analgesic, and hypnotic agent available to man today. This substance has been the layman's panacea and the poor man's psychiatrist since the beginning of recorded time, and, as an afterthought, probably will continue to be so for a long time to come. The bootlegger may not know how to express it in just the above terms, but he does know that there will always be a ready market for his wares.

It is suggested, then, that in the learning process required to become a solidly qualified member of the cult of alcoholism, one learns, without much difficulty, to be his own physician and to treat his own psychological ills, as well as his later physical ills, by self-prescription. As a fledgling in the business, he learns that his medicine works remarkably well for a feeling of anxiety and, or, inhibition in his tumultous adolescent years. He becomes less of a wallflower, at least he thinks he is a better dancer, he becomes a little less inhibited on the highway and he may even dispense a little to his girl friend whom he finds becomes more amorous with *his* magic potion. And so he establishes solidly his novitiate in the cult of alcoholism. Depending upon his previous experience of life (an alcoholic father for example) and what life does to him in his future, will determine his further develop-

ment in the cult or whether he remains at the novitiate or beginner's level.

Suppose, for example, that he should become enamored of a young lady who by more than chance happening knows that he tipples some, maybe even a little too much for her, and whose father is a full-fledged member of the cult! Then conditions are just right for his further development in the cult, for he has encountered now the reformer who will only serve to stiffen his faith and force him (unconcsiously of course) to assert his primitive masculinity which he can do only in mystical union with his deity, alcohol. So he comes closer to confirmation in his development in the cult. He will soon, with practice, learn more about the unique power of his ingested deity and then discover with a tremendous burst of insight that alcohol can and does do anything for him. He then desires to remain in constant union with it to the death of this mortal life. He is its slave. In too brief compass this, then, is the story of the member of the cult of alcoholism.

Let us now drop the extended analogy that was employed to give understanding to the concept of alcoholism as a learned way of life, and plough a little deeper into two of the more serious psychological disturbances that underly the serious disease of alcoholism and which are self-treated for so long by the individual involved.

The underlying psychological illnesses are severe enough to warrant the collective designation *alcoses,* and to further warrant a differentiation of two recognizable clinical conditions, based upon the underlying dynamics, of *alcopression* and *alcophrenia.* It will remain, at a later date, to designate a large group of not-yet alcotics as *alceurotics* whose use of alcohol is not yet of severe addictive proportions, but which is the recognizable self-treatment of underlying neurosis by the use of alcohol. This group will be discussed in a later article.

Alcopression. One serious psychopathologic condition which receives so much prolonged self-treatment with alcohol is depression. This writer's experience with this combination-type illness of depression and alcohol has so impressed him that the condensation of the terms *alcohol* and *depression* into *alcopression* seems a natural designation of this clinical entity.

The psychologic illness of depression is exceedingly common in our population. As psychosomatic medicine has taught us, a great many psycho-physiologic illnesses have as their underlying stress factor the depressive syndrome with its characteristic pattern of a recent personal, actual or threatened, symbolic loss as a precipitating event. Such persons typically present themselves as feeling tired all the time, without energy. Their appetites are poor and they lose weight. They complain of not being able to sleep: they either can't get off to sleep, or else they wake up early and can't go back to sleep. They are often overweight initially and may lose weight, a fact which alarms them terribly. They may have chronic, ill-defined headaches all the time; or their illness may find expression in gastro-intestinal or respiratory disturbances. And ultimately in dealing with them, one finds the ever-present underlying

pattern of an overdependent-hostile relationship with literally any helping person they come into contact with. Although superficially pleasant to the point of suspicion, one always feels that one is dealing with loaded dynamite. Refuse them one request and they will sulk off and tear you to pieces verbally with anyone who will listen. Dynamically oriented persons will recognize the conflict situation here of tremendous hostility repressed at terrific emotional cost.

Many so-called alcoholics, or alcopressives as this writer calls them, characteristically present this well-known syndrome of depression with its classic dynamics of loss, ambivalent hostile-dependent relationships, and a very strict conscience (or superego if you wish) that will not tolerate any expression of hostile actions or impulses. And certainly enough, some persons discover that depression is marvelously well-treated without a doctor's prescription or services by a very available and fast acting euphorogenic chemical substance called alcohol. Don't be fooled by the fact that ethyl alcohol is a depressant drug. It is. Basically it is an anesthetic. Nevertheless, it does in the early stages of intoxication produce euphoria. It makes people *feel* good and their mood changes from blueness and despondency to mild euphoria. In this sense then, though the process of anesthesia begins with the very first drink, it has an antidepressant effect psychologically. There is an outstanding parallel to this in nitrous oxide or "laughing gas."

When it is stated that an individual treats his own depression with alcohol, the statement is made in all seriousness. Let us analyze for a moment how this works. Take the symptom of some loss precipitating a given drinking bout. In one particular case a man, who had gone 14 years without touching a drop, pitched two successive benders of about two months each immediately following the death of his mother. Sometimes it is the repeated threats of a distraught spouse to leave if he fails to stop drinking that represents a loss that precipitates, prolongs or intensifies his drinking episodes. In this type of drinker, there is almost always—if one will look for it—some actual loss, threatened loss, or symbolic loss in the drinker's recent experience, and he proceeds to "drown his grief" as they say, with alcohol. Temporarily, at least, the anesthesia of alcohol enables him to forget the value of the lost object and its tremendous emotional value to him.

Or, again, look how alcohol fulfills the dependency-hostility conflict. The intoxication self-induced by those who drink to relieve depression can be seen as at once *forcing* a responsible society or spouse to literally take care of them hand and foot, while at the same time they can curse society for attempting to do it. It is the picture of the horns of a dilemma he can hang any would-be helper upon by making himself helpless with alcohol (although he will not admit he's helpless). He will make you fulfill his tremendous dependency needs, and when you don't do it to precisely suit him, he'll curse you at the drop of a hat. He can at once be regressed and force the being taken care of and, at the same time, ventilate a lot of his repressed hostility on whoever happens to be

around—just by getting intoxicated. And by so doing he treats some of the underlying dynamics of his depression: the fulfillment of his intense dependency needs and the ventilation of his repressed hostility.

The vicious cycle continues. When in the course of his drinking the blood level of alcohol begins to drop and his anesthetized conscience begins to awaken and to reproach him, he knows only too well that alcohol is one of the best dissolvers of the superego known to man, and a few more drinks can still that reproaching inner voice very quickly. What more could he ask for? His guilt feelings—an essential part of any depressive syndrome—are at least temporarily removed, and the chemical form of treatment is once again effected.

One can now begin to understand what is meant when we call alcohol an antidepressant which the alcopressive uses by self-prescription to treat his depression. He drowns his grief over loss with alcohol's anesthesia. He obtains gratification of his excessive dependency needs by forcing someone to take care of him in his helpless (but denied) state. He can safely ventilate his surcharge of repressed hostility by the disinhibiting effects of alcohol. He can still his punitive superego very effectively with more alcohol should it reproach him. And because of his treatment of himself in this manner, he tends to forestall the development of clinical depression in the alcohol-free state for years—or at least it seems so.

In actuality, however, we all know and agree with Menninger's statement that in reality he is slowly achieving the goal of every depression, death, by the slow, progressive deterioration of his mind and body. He only makes certain it is painless.

We have taken pains to describe the manner by which an individual may be a so-called alcoholic through the self-prescribed treatment of his underlying depression. There are, however, other ways that he may achieve the status of the condition we now call alcoholic. Space permits the very brief description of one more:

Alcophrenia. It must be remembered that the process of anesthesia can be thought of as the process of regression. In other words, anesthesia takes one back in time by anesthetizing the successive layers of experience in time that the mind records. That alcohol works in this manner is an easily observable phenomenon. This observer sat with an inebriated fellow most of one night to prove this point to himself, and has repeated the observation from time to time since in order to broaden the base of the concept. The time sequences were later checked with the inebriate in a fully recovered state.

One case is recalled full well because the fellow was most unhappy. He had only enough alcohol to carry him back to his war experiences and he talked for hours about them. This had been 20 years back. As his body gradually eliminated the alcohol, he began to talk of more recent events, such as his marriage after the war, the birth of his children, his successive jobs, all without direction or questioning. His productions were spontaneous and attended by exaggerated emotional expressions appropriate to the thought content of the time in the past in which he was living. As the hours passed and he "sobered up," it was noted that he continually talked of more recent events right up until the then-present

moment.

Because alcohol is so slowly eliminated from the body, one can, if he notes carefully the chronologic sequence of events talked about, trace the course of many significant events in the past history of the inebriated person. At first they may sound like babble, the associations weird to the rational mind, fact mixed with fancy, and repetitious to the point of exasperation, but if one listens and gets to know his patient well, one will see this phenomenon of regression and counter-regression occur as he sobers up. It is a fascinating, but time-consuming, exercise.

The point is being made that alchol, due to its anesthetic action, is a *regressogenic* chemical substance which can and does take one back mentally and emotionally in time—right back to the barely self-conscious awareness of the infant who sleeps 22 out of 24 hours or more. Many a spree drinker has repeatedly carried himself back to that point and kept himself there for days at a time. He takes to the bed in actuality and his spouse brings him the magic liquid.

Once a drinker discovers that he can use alcohol to regress in this manner, or to retreat or withdraw from the face of a threatening or conflict situation—be it in his environment, the people or situations in that environment, or emotional conflicts within his own environment—and "forget" the present by moving into the past, he has learned an important lesson in the self-preservation of the integrity of the ego. He can regress from the face of conflict for a time—stop the clock so to speak—and give his beleagured feelings and thoughts a rest by chemical means. It is temporary surcease, to be sure, but it is surcease and it is rest for the mind. Awakened, the conflict may still be there or, as he secretly hopes, has resolved itself while he was out of it.

In short, he has produced for himself a beautiful case of a temporary, chemically-induced schizophrenic syndrome. He's drunk. If his actions and words do not fit the situation, he is not responsible. He's drunk. No, he's not drunk. He is as the Roman philosopher, Seneca, once so perceptibly stated: "Drunkenness is nothing but insanity purposely assumed." He is in a temporary state of chemically-induced schizophrenia, the main symptoms of which are autism, ambivalence, affective disturbance and withdrawal of the self from the world of persons. Rather than be called the meaningless term, alcoholic, might he not be better called an alcophrenic and his psychologic-physical disease be called alcophrenia? Your serious thought is invited to the concept, for it is felt that the term more accurately describes this particular type of drinker.

Summary

In this brief paper a defense of the appropriateness of the term "alcoholism" is attempted since it is felt that it is an accurate generic term for the whole range of clinical disturbances that appear with one common outstanding symptom. Alcoholism was defined essentially as a way of life involving the use of a self-prescribed chemical agent which can insure instant happiness. It is argued that the development of this disease is essentially a learning-by-doing experience, the culmination of which depends upon many factors. Two serious expressions of the disease were described in terms of their etiologic development and psychodynamic formulations, namely the alcoses of alcopression and alcophrenia. The alceuroses are left for a later description.

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refer him if he thinks it is necessary, the likelihood of the referral being successfully carried through is increased.

There is danger in referring the alcoholic too quickly so that he interprets the referral as rejection on the part of the minister.

The individuals for whom immediate referrals should be made are the acutely ill, those suffering delirium tremens for example. They should be referred to the general hospital or sanitorium for immediate care. The chronically ill may be referred to the rehabilitation clinic or to A.A. And the more emotionally disturbed ones may be referred to a psychotherapist.

Seward Hiltner has wisely observed that if the alcoholic has been prepared emotionally for the particular help psychotherapists and other specialists can offer, he would not have come to the pastor. Therefore, it is more expedient for the pastor to consult at some length with the alcoholic in order to build rapport before referring him even to A.A. (Hiltner, *Helping Alcoholics,* p. 8).

Following such a referral the pastor does well to maintain friendly contact with the alcoholic and leave the door open for him to return as well as to keep in touch with him through his therapist or A.A. sponsor.

Patience is of essence in making a referral and the minister who is offended by the alcoholic's resistance to his recommendation of A.A. or of a rehabilitation clinic will be ineffective over a long period of time because *most alcoholics deny to the bitter end that they need outside help in dealing with their drinking problem.* Rarely does one go to A.A. or to a clinic as soon as the family, physician, or the minister suggests it. The minister should recognize this inevitable strength to resist outside suggestions is also the fountain of strength from which will come the fuel to achieve sobriety. On the other hand, the alcoholic who is not resistive and who is so eager to please his family or his minister is likely to be the one to succumb to the influences of his drinking friends or to his inner tensions that lead him to believe he needs "just one little one."

Clinical experience has verified the necessity for formulating some basic principles important in counseling with alcoholics. Among these are:

1. Discern who is seeking help, the alcoholic, the friend, or a relative of the alcoholic.
2. Permit the alcoholic to make the decision as to whether he will pursue help through any of the available channels.
3. Accept his decision to postpone getting help until such time as he may be ready and encourage his family to do the same.
4. Reflect the concept that the alcoholic is a sick person, not an evil one.
5. Exact no promises or vows from the alcoholic.
6. Remember if one sees himself as the "Good Samaritan" he will likely be preoccupied with his own feelings rather than those of the alcoholic.
7. Accept his expression of guilt without condemnation or quick reassurance.
8. Use no method of shaming the alcoholic to try to make him reform.
9. Avoid trying to convince an alcoholic of the folly of his ways while he is drinking heavily.
10. Appeal to the alcoholic's personal desire for sobriety rather than for the sake of his family or com-

munity.

11. Provide firm limits within which the alcoholic may operate thus helping the alcoholic to respect himself and his ability to make decisions.

12. Express genuine interest without becoming overly involved; otherwise unnecessary frustration on the part of the minister will occur. For example, if the alcoholic feels a need to experiment with drinking, the minister need not feel that he has personally failed.

While many people continue to seek to find a simple, easy answer for the cause, the course, and the cure of alcoholism, the pastor should not be misled into expecting to make such a Utopian discovery. Alcoholism is a field in which relatively little research has been done, and in which the need for such is great. It is one in which too few capable people are engaged in treatment and one from which the minister is often too far removed. The more than five million men and women in America who still suffer from this emotional disorder need the help of the pastors who have an open-mindedness to accept truth wherever it can be discovered.

The distinctive role of the pastor in counseling with alcoholics and their families is not simply in his highly skilled counseling techniques, not in his unique awareness of men, but rather in his upward call which prompts him to gain greater understanding and to perfect his skills in rendering devoted service to the lonely and the loveless. The minister's privilege is to follow in the train of Jesus who described the nature and scope of his ministry by identifying himself with Isaiah's mission ". . . to bind up the brokenhearted, to proclaim liberty to the captives, and the opening of the prison to them that are bound . . ." (Isaiah 61:1).

A NEW NAME FOR ALCOHOLISM?

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But advances have been, and are being, made. Today, more than ever before, alcoholism and the alcoholic are being discussed in newspapers, city planning groups, periodicals, motion pictures, radio, television, and many other educational and advertising media.

One can scarcely overlook the educational program of local councils on alcoholism, as engineered and promoted by the National Council on Alcoholism. Through a network of 78 affiliates, local communities are combating not only the stigma of alcoholism, but paving the way for all types of therapeutic and preventive programs.

The North American Association of Alcoholism Programs, a group representing official state agencies involved in alcoholism, extends the state program to the local level, setting the stage of local-state affiliations in control efforts.

Rather than change the term alcoholism, which is well on the way to general acceptance, if local communities organize and the general trend of discussion continues, would it not be of greater value to emphasize education of our present terminology, rather than necessitate a complete change-about-face.

Education is the greatest force to eliminating the stigma of alcoholism. But this education must be approached in a business venture. In other words, education, professionally directed—not subjectively promulgated.

It is time that our local communities organize, and use modern methods—catchy, colorful, and dramatic television and radio messages . . . professional literature and pamphlets . . . secondary and college level programs . . . medical and nursing school curricula . . . industrial alcoholism programs. And they will, if the full effect of alcoholism on the individual, the family, and society are adequately and effectively presented.

Though the presence of the patient is helpful, a plan of treatment for the resistant alcoholic may be worked out by the family with professional assistance and initiated without his cooperation.

TREATMENT OF THE RESISTANT ALCOHOLIC

BY EARL M. MITCHELL, M.D.

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ALMOST everyone now believes that the alcoholic patient can recover and that alcoholism is a treatable disease. It is usually assumed that the victim of alcoholism need only to be told this, that he find someone to give the proper treatment, and all will be well. Unfortunately, this simple approach is not effective when the patient resists treatment, is uncooperative or denies the existence of a drinking problem. Nor can one find much comfort in saying, "A patient cannot be helped until he is ready for help." Watchful waiting permits the progression of alcohol addiction to the point where recovery becomes less and less likely, perhaps even impossible. It is wrong to place all the blame for the therapeutic failure on the patient. There is no other illness where responsibility for diagnosis and treatment rests entirely upon the patient.

Since early diagnosis and treatment of alcoholism is so important if the rate of recovery is to be increased to more than the present figures, we must learn to help the alcoholic as soon as the problem is suspected even though the patient may be unwilling to accept treatment.

Though the presence of the patient is helpful it is not necessary to have the cooperation of the alcoholic to begin a treatment program. The first interview with the family will be devoted to history taking and collecting facts about the patient, attitudes of members of the family toward the patient, and arriving at some estimate of the emotional resources which are available to deal with the problem. The purpose of these interviews will be to form some plan which will vary according to the physical and emotional disturbance present in the patient and his family.

The following general principles may be useful as guides in treatment planning:

1. Discourage the family from using "home remedies"—pouring out or locking up the liquor, nagging, arguing and using emotional appeals, such as: "How can you do this to me?" "Where is your self-respect?" "Think of the children."

It is best that the family no longer oppose drinking at this level. They should learn about alcohol addiction and what to do about it. They will need guidance and counseling for this purpose.

2. The family should stop protecting the alcoholic and should allow the patient to work out the difficulties which have been caused by his drinking. Overprotection by the family encourages continuing dependency and further drinking.

3. The patient should be told that the family has consulted someone about this family problem and that they are going to continue to seek help. The alcoholic should be encouraged to discuss the problem with the counselor or therapist but not forced to do so.

4. The family should recognize that they cannot force the alcoholic to stop drinking. He must do this for himself. However, their positive and hopeful attitude can make this step easier.

5. The family should rely on one or more continuing sources of assistance so that they may develop better insight in dealing with this problem. These sources of assistance include Alcoholics Anonymous, Al-Anon Family Groups, clergymen, physicians, psychiatrists and the community alcoholism clinic.

6. The family must recognize that recovery is slow and often difficult and requires many months. Relapses which may occur during this time should not be interpreted as failure of the treatment program.

After a plan of treatment is worked out and is acceptable to the family, they must be prepared to follow through with the recommendations of their counselor or therapist. No threat or ultimatum should be issued without careful thought and unless there is full intent to carry it out. Best results are obtained when the family is fair but firm in dealing with the alcoholic.

So far this article has discussed the attitudes of the family toward the alcoholic

Best results are obtained whe

and suggestions have been made concerning their responsibilities and usefulness in encouraging the alcoholic to begin treatment. It will now suggest how the family may proceed to use the information that they have learned.

If the patient is in control of his behavior, a permissive approach and the use of gentle persuasion is useful. During this time the family should attempt to control their own tensions and anxieties and should rely upon their family counselor to help them deal with these destructive feelings about the drinking. The patient may be invited to join in this effort with the suggestion that impartial counseling will permit him to discover whether he is a problem drinker or not. If the family stops trying to control the patient's intake of alcohol this will remove one of the strongest arguments that the patient may use for justifying his drinking. The family should avoid arguments while the patient is intoxicated even when the alcoholic provokes the argument. These suggestions are difficult for some and impossible for others to follow, but if the problem drinker is in the early stages of alcoholism these simple changes of attitude may be sufficient to bring the patient into active treatment.

If after several weeks or months there is no improvement a firmer attitude is suggested. The family should explain that the present behavior is not acceptable and that some changes will have to be made soon. The family may point out that they will no longer protect the alcoholic or assist him to conceal his drinking. The patient will be asked to take responsibility for his drinking and its consequences. The family should remind the alcoholic that help is available and that some professional assistance possibly would be able to resolve the problem.

If this fails and the problem continues,

stronger forces may be needed to initiate participation in a therapeutic program. Loss of economic security, loved ones, or personal freedom are obviously powerful forces and their misuse may have serious consequences. However, if properly used one or more of these forces may be the means of bringing the full impact of the reality to the attention of the alcoholic and thereby help him to begin his recovery. These measures should be used only after careful thought and consideration of possible benefits as well as their dangers.

When the patient's employer cooperates with the family in bringing this problem to the attention of the patient, he may quickly become convinced that he must do something about his drinking. However, if a threat of loss of job is made the threat must be carried out if drinking continues.

The threat of breaking up the family should be reserved for the patient who has repeatedly rejected or ignored all other offers of help and who has made no effort to accept treatment. The family should be told that the separation may cause the drinking to become worse, that further loss of self-esteem and depression resulting from this separation may cause further progression of drinking, or even attempted suicide. Or the whole picture may change to a more hopeful one. It is impossible to promise the family what the outcome will be and there can be no easy answer for the family facing this decision. Each person in the last moment must decide this for himself. Some should take this step and others should not.

Forcible confinement in a hospital should be considered as a last resort and may be necessary for the resistant alcoholic. I believe commitment has a very definite value and it can well be the turning point in severe alcoholism. Hospital treatment, even when forced upon a patient, may be useful because, in advanced illness, the alcoholic may suffer considerable impairment of judgment and be unable to think clearly as a result of the toxic and depressant after effects of alcohol upon the cerebral cortex. The patient may require several weeks or months of abstinence to fully regain cortical function. A controlled environment, especially one which offers a program of rehabilitation may succeed when the patient is untreatable at home. Commitment can be a human life saving measure and its use is recommended for those who have not responded to any other treatment.

Continued assistance for both the alcoholic and his family is very important, and treatment should include regular follow-up visits for both. The alcoholic may relapse, especially when treatment is too short or is inadequate. The most useful single resource for the follow-up period is the fellowship of Alcoholics Anonymous, which helps to prevent further drinking and provides an opportunity for emotional and spiritual growth. The follow-up program may also include visits to a professional worker or alcoholism clinic and sometimes all of these treatment resources are required.

To summarize:

1. When the patient does not want to accept treatment for alcoholism it is useful to work with the family so that they may develop an understanding of this disease and learn their own relationship to the problem.

2. The family can bring the forces of reality to bear upon the alcoholic so that he will find it possible to accept treatment.

3. Continuing assistance for the alcoholic and his family is necessary in order that they may find a lasting solution to their problem.

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ASHEVILLE—

**Alcohol Information Center;* Mike Dechman, Educational Director; Parkway Offices; Phone: 704-252-8748.

†*Mental Health Center of Western North Carolina, Inc.;* 415 City Hall; Phone: ALpine 4-2311.

BURLINGTON—

**Alamance County Council on Alcoholism;* Margaret Brothers, Executive Director; Room 802, N. C. National Bank Building; Phone: 919-228-7053.

‡*Outpatient Clinic;* Alamance County Hospital; Hours: Wed., 9:00 a.m. - 4:00 p.m.

BUTNER—

‡*Aftercare Clinic;* John Umstead Hospital; Hours: Mon. - Fri., 9:00 a.m. - 4:00 p.m.

CHAPEL HILL—

†*Alcoholism Clinic of the Psychiatric Outpatient Service;* N. C. Memorial Hospital; Phone: 942-4131, Ext. 336.

**Orange County Council on Alcoholism;* Calvin Burch, Box 277, Carrboro.

CHARLOTTE—

**Charlotte Council on Alcoholism;* Rev. Joseph Kellermann, Director; 1125 E. Morehead St.; Phone: 704-375-5521.

‡*Mecklenburg Aftercare Clinic;* 1200 Blythe Blvd.; Hours: Mon. - Fri., 8:00 a.m. - 5:00 p.m.

†*Mental Health Center of Charlotte and Mecklenburg County, Inc.;* 316 E. Morehead St.; Phone: 704-334-2834.

CONCORD—

†*Cabarrus County Health Department;* Phone: STate 2-4121.

DURHAM—

‡*Aftercare Clinic;* Watts Hospital; Hours: Tues. and Fri., 2:00 - 5:00 p.m.

**Durham Council on Alcoholism;* Mrs. Olga Davis, Executive Director; 602 Snow Bldg.; 919-682-5227.

FAYETTEVILLE—

†*Cumberland County Guidance Center;* Cape Fear Valley Hospital; Phone: HUdson 4-8123.

GASTONIA—

†*Gaston County Health Department;* Phone: UNiversity 4-4331.

GOLDSBORO—

‡*Outpatient Clinic;* Cherry Hospital; Hours: Tues. and Fri., 10:00 a.m. - 12:00 noon. Thurs., 2:00 - 4:00 p.m.

**Wayne Council on Alcoholism;* H. B. Hulse, Executive Director; P. O. Box 1598. Phone: 919-735-7033.

GREENSBORO—

**Greensboro Council on Alcoholism;* Worth Williams, Executive Director; 216 W. Market St., Room 206 Irvin Arcade; Phone: 919-275-6471.

†*Guilford County Mental Health Center;* 300 E. Northwood St.; Phone: BRoadway 3-9426.

†*Family Service Agency;* 1301 N. Elm St.

‡*Outpatient Clinic;* 300 E. Northwood St.; Hours: Mon. and Thurs., 5:00-10:00 p.m.

GREENVILLE—

**Pitt County Alcohol Information and Service Center;* Helen J. Barrett, Executive Secretary; P. O. Box 2371; 915 Dickinson Ave.; Phone: 919-758-4321.

†*Pitt County Mental Health Clinic;* Pitt County Health Department, P. O. Box 584; Phone: PLaza 2-7151.

HENDERSON—

**Vance County Program on Alcoholism;* Dr. J. N. Needham, Director; 2035 Raleigh Rd.; Phone: 919-438-3274 or 919-438-4702.

HENDERSONVILLE—

Alcohol Information Center; S. Robertson Cathey, Director; 2nd Floor, City Hall; Phone: 919-692-8118.

HIGH POINT—

†*Guilford County Mental Health Center;* 936 Mountlieu Ave.; Phone: 888-9929.

JAMESTOWN—

**Alcohol Education Center;* Ben Garner, Director; P. O. Box 348; Phone: 919-883-2794.

LAURINBURG—

**Scotland County Citizens Council on Alcoholism;* M. L. Walters, Executive Secretary; 308 State Bank Bldg.; P. O. Box 1229; Phone: 919-276-2209.

MORGANTON—

‡*Aftercare Clinic;* Broughton Hospital; Hours: Mon.-Fri., 2:00-4:00 p.m.

NEW BERN—

**Craven County Council on Alcoholism;* Gray Wheeler, Executive Secretary; 411 Craven St., P. O. Box 1466; Phone: 919-637-5719.

**†Psychiatric Social Service,* Craven County Hospital; Phone: 919-638-5173, Ext. 294; Hours: Mon.-Fri., 9:00 a.m.-5:00 p.m.

NEWTON—

**Educational Division, Catawba County ABC Board;* Rev. R. P. Sieving, Director; 130 Pinehurst Lane; Phone: 704-464-3400.

NORTH WILKESBORO

Wilkes County Council on Alcoholism; William S. Call, Executive Director; Old Elementary School Bldg.; Phone: 919-838-6046.

PINEHURST—

Sandhills Mental Health Clinic; Box 1098; Phone: 295-5661.

RALEIGH—

‡*Aftercare Clinic;* Dorothea Dix Hospital, S. Boylan Ave.; Phone TEmple 2-7581; Hours: Mon.-Fri., 1:00-4:00 p.m.

†*Outpatient Clinic of the Mental Health Center of Raleigh and Wake County, Inc.;* Wake Memorial Hospital; Phone: 834-6484; Hours: Mon.-Fri.; 8:30 a.m.-5:30 p.m.

SALISBURY—

**Educational Division, Rowan County ABC Board;* Peter Cooper, Director; P. O. Box 114; Phone: 919-633-1641.

†*Rowan County Mental Health Clinic;* Community Bldg., Main and Council Sts.; Phone: MElrose 3-3616.

SANFORD—

†*Mental Health Clinic of Sanford and Lee County, Inc.;* 106 W. Main St.; P. O. Box 2428; Phone: 775-4129 or 755-4130.

SHELBY—

†*Cleveland County Mental Health Clinic;* 101 Brookhill Rd.; Phone: 482-3801.

SOUTHERN PINES—

**Moore County Alcoholic Education Committee;* Rev. Martin Caldwell, Director; P. O. Box 1098; Phone: 919-692-6631.

WADESBORO—

**Education Division, Board of Alcohol Control;* Robert M. Kendall, Director; 125 W. Wade St.; P. O. Box 29; Phone: 704-694-2711.

WILMINGTON—

**Mental Health Center of New Hanover County;* 920 S. 17th St.; Phone: 763-7342.

**New Hanover County Council on Alcoholism;* Mrs. Margaret Davis, Executive Secretary; 211 N. Second St.; Phone: 919-736-7732.

WILSON—

‡*Aftercare Clinic;* Encas Station; Hours: Mon.-Fri., 8:00 a.m.-5:00 p.m.

†*Wilson County Mental Health Clinic;* Encas Rural Station; Phone: 237-2239.

WINSTON-SALEM—

**†Alcoholism Program of Forsyth County;* Marshall C. Abee, Executive Director; 802 O'Hanlon Bldg., 105 W. 4th St.; Phone: 919-725-5359.

WISE—

**Warren County Program on Alcoholism;* Rev. W. G. Coleman, Director; Box 100; Phone: 919-257-4538.

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Films—on alcohol facts and personality health for distribution among roups interested in brief, factual motion picture studies. Obtainable from the Film Library, N. C. State Board of Health, Raleigh, N. C. Please request films as far in advance as possible and state second and third choices.

The ARC Brochure—illustrated booklet on North Carolina's program for treating alcoholism as an emotional sickness.

The New Cornerstones—Family manual giving basic facts about alcoholism and suggestions for coping with the personality sickness.

Library Books—Books on alcoholism are available from the North Carolina State Library through local libraries to residents of North Carolina. To obtain any of the books listed in the March-April, 1964 issue of **Inventory,** go to your community library and make the request.

Staff Speakers—members of the Raleigh and A.R.C. staffs are available for speeches before civic and professional groups.

Book Loan Service—kits containing reference books and pamphlets on alcoholism. Available to teachers from the Education Division, N. C. Department of Mental Health, Raleigh.

Consultant Service—for establishment of local programs.

These services are free upon request of citizens residing in North Carolina. For free materials in limited quantity, write

Education Division, N. C. Department of Mental Health
P. O. Box 9494
Raleigh, N. C. 27603

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